STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 89339-001**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 23rd day of June 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 22, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 29, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Regulation received BCBSM's response on May 8, 2008.

The issue in this external review can be decided by a contractual analysis. The contract that defines the Petitioner's health care benefits is the BCBSM Professional Services Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner underwent a reconstructive procedure for wound closure on her upper lip on November 24, 2006. This care was provided in XXXX by a nonparticipating surgeon. The surgeon's charge was $1,548.00, but the local Blue Cross Blue Shield plan approved its maximum payment amount of $373.12 for this care.

The Petitioner appealed the payment amount. BCBSM held a managerial-level conference on February 27, 2008, and issued a final adverse determination on February 29, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the surgical services provided to the Petitioner on November 24, 2006?

IV
ANALYSIS

Petitioner's Argument

While on a visit to XXXXX the Petitioner tripped and fell on her face in the street and seriously injured her upper lip. She was taken to the emergency room at XXXXX Hospital where the damage was repaired by a physician that does not participate with BCBSM or a local Blue Cross Blue Shield plan.

The doctor charged $1,548.00 for the care, but BCBSM only paid $373.12. The doctor billed the Petitioner for the $1,174.88 balance.

The Petitioner argues that BCBSM is required to pay the full amount charged for her care since it was provided on an emergency basis at the emergency room of a hospital. She believes the certificate provides full coverage for emergency room care regardless of the location. In addition, she says she had no control over who provided her emergency care and had no knowledge that the doctor did not participate with Blue Cross Blue Shield.

BCBSM's Argument

BCBSM says it correctly paid for the services the Petitioner received from a nonparticipating provider.

Section 2 of the certificate, *Coverage for Physician and Other Professional Services,* explains how BCBSM pays nonparticipating providers. It says that BCBSM pays its "approved amount" for physician and other professional services – the certificate does not guarantee that charges will be paid in full. In addition, since the surgeon in this case does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full and may bill for the balance of the charge.

BCBSM says the maximum payment level for each service is determined by a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, is regularly reviewed to address the effects of changing technology, training, and medical practice, and is adjusted by geographic region.

BCBSM contends that it has paid the proper amount for the Petitioner's care based on the provisions of the certificate and is not required to pay more.

Commissioner's Review

The certificate explains that BCBSM pays an "approved amount"[1] for physician and other professional services. The approved amount is defined in the certificate on page 4.1 as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating and panel providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

1 Because the services were performed in XXXXX, BCBSM used the maximum payment level of the local Blue Cross Blue Shield plan as its approved amount.

The certificate explains (on pages 2.21):

> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid the full maximum payment level for the Petitioner's care on November 24, 2006. Nothing in the record establishes that BCBSM is required to pay any additional amount for this care. It should be noted that there is no difference in the amount BCBSM reimburses participating and non-participating providers.

It is unfortunate that the Petitioner was not able to use a participating provider. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than the approved amount to a nonparticipating provider, even if the care was provided on an emergency basis or even if no participating provider was available.

The "Benefits-At-A-Glance" summary that was provided the Petitioner indicates that emergency room care is "covered." However, this means that BCBSM is required to pay for emergency room care according to the terms and conditions of the certificate – it does not mean that BCBSM is required to pay the full amount charged by a nonparticipating provider.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

The Commissioner upholds BCBSM's final adverse determination of February 29, 2008. BCBSM is not required to pay an additional amount for the Petitioner's November 24, 2006 care.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham

County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.